able amount of literature has accumulated that discusses issues arising between black therapists and white clients, and between white therapists and black clients.

Unique problems can also arise when the therapist and client are both black. Themes that frequently present as countertransference issues include denial of identification, overidentification, and class differences and similarities between therapist and client. External and internal obstacles to be mastered by the black psychiatrist at leadership helms, if he is to be effective in his relationship with black clients, include professional identity hurdles, personal anxieties and fears, ethnic identity issues and leadership problems.

These hurdles can be overcome when the black physician can resist the seductive notion that his "black skin" adequately substitutes for objectivity and scholarly endeavor.

These issues have relevance, not only for the black physician and black client, but also for white medical professionals who will increasingly be mentors to black trainees in otherwise predominantly white medical centers.

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## Psychiatric Emergency Services

Community need for 24-hour, 365-day, comprehensive psychiatric emergency services (PES) is now commonly recognized. Basic program elements include: (a) telephone interviewing; (b) walk-in evaluation; (c) continuous observation and treatment capability for up to 12 to 24 hours; (d) referral and referral-success check system; (e) capability for serving involuntary as well as voluntary patients; and (f) linkage to a medical-surgical emergency service, and to psychiatric hospital, outpatient crisis, drug and alcohol abuse intervention units. Other desirable features are: (a) a physically separate area to house the PES;

(b) follow-up visit capability for up to one week; and (c) mobile unit for community service

Common intervention modalities include: (a) the preliminary evaluation itself, in which clarification, catharsis and reassurance are frequently therapeutic; (b) counseling with patient and relatives; (c) medications; (d) on-unit patient group activities; (e) environmental manipulation; and (f) PES-catalyzed natural improvement. These techniques quickly reduce emotional and behavioral disturbance and often prevent psychiatric hospitalization, especially for many transiently anxious, angry, intoxicated, depressed, and initially suicidal patients.

A PES should always have a physician on duty (psychiatrist or other physician with telephone back-up by a psychiatrist) because of the frequent acute psychotic and delirious states requiring differential diagnosis and rapid drug therapy. Nursing personnel require special in-service training in emergency intervention. Well trained and supervised non-professionals (volunteers or indigenous paid mental health workers) participate ably in several aspects of intervention. Child PES visits are uncommon, but a good service should have child mental health consultation available by telephone.

The major problem of the PES is the high cost of its safe and successful operation. However, a well run, well-linked PES reduces yet more costly service, therefore justifying this expense.

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The Lateral Specialization of the Human Brain for Cognition; EEG And Lateral Eye-Movement Studies

We are studying the lateral specialization for cognitive function. In one study, we recorded the EEG from the temporal and parietal areas